STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005066	A. BUILDING: _____ B. WING _____	10/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL	1101 MICHIGAN AVE LOGANSPORT, IN 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital complaint investigation. Complaint: #IN00134887 Unsubstantiated; lack of sufficient evidence. Survey Date: 10/22/13 Facility #: 005066 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Memorial Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules. QA: claughlin 11/01/13	S 000		